January 6, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0216 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## CLINICAL HISTORY

___ was injured on her job when she stepped on a slippery floor and fell, causing a sprain/strain to the cervical and lumbar spines, a right ankle sprain and a right hip contusion. She was treated initially with passive therapy. MRI of the right ankle was negative for frank pathology and the cervical MRI did demonstrate herniations of 2-2.5 mm at the level of C3-C4 and C4-C5. The actual finding is not presented in the cervical spine, but rather a summary of the findings. It is presumed to be accurate by the reviewer. MRI of the lumbar spine did display with degenerative changed with some bulging at the L4/L5 level. A diagnosis was made by ___, of a cervical radiculopathy. No EMG is presented for review of the cervical spine, but ___, did interpret EMG findings and stated there was no lumbar radiculopathy.

## REQUESTED SERVICE

The carrier has denied 30 sessions of chronic pain management.

## DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient has predominantly had sprain/strain injuries. While there were some issues that this patient has documented in this file, high clinical scores on depression, anxiety, hostility and symptom dependency are not likely to be corrected by a pain management program. Indeed, the system dependency is likely due to a treatment protocol by the treating doctor as opposed to relation to pain. The same is likely to be the case for the depression, anxiety and hostility. It is very probable that if the patient is severely depressed and system dependent, success in the program would be impeded by compliance issues as well as the very probable situation that a patient with this syndrome could not complete such a program with 8 hour days. As a result, I do not feel that this program is documented as being appropriate for a patient of this condition.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request. The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).